2014-2015 Insurance Information Form

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * _____ ____ _____ Month Day Year	Age*	Sex: (Circle)* Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone:* ( )

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
Medicare Number:	Is Medicare Primary? Yes No	Is Subscriber Retired? Yes No

If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * _____ ____ _____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

I give permission for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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***Place Photo Copy of All Insurance Cards Here:**

Provider Name: _____ MDPH Provider PIN#: _____

Provider Address:

_____

2014-2015 Insurance Information Form

For children 18 years of age and younger:

Is Vaccine for Children (VFC) Program eligible:

- ☐ Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
- ☐ Does not have health insurance
- ☐ Is American Indian (Native American) or Alaska Native

Is not VFC-eligible:

- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

For Clinic/Office Use Only:

Signature of Vaccine Administrator: _____

Date of Service	Vax Type	Vaccine Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied (Circle)	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given
	IIV3				0.25 0.5	No	Yes No	IM	R Arm L Arm R Leg L Leg		
	ccIIV3	Novartis			0.5	No	Yes	IM	R Arm L Arm		
	IIV3 Intradermal	Sanofi Pasteur			0.1	No	Yes	Intradermal	R Arm L Arm		
	IIV3 High Dose	Sanofi Pasteur			0.5	No	Yes	IM	R Arm L Arm		
	IIV4	Sanofi Pasteur	UI 196 AB	06/30/15	0.5	Yes No	No	IM	R Arm L Arm R Leg L Leg	8/19/14	
	RIV3	Protein Sciences			0.5	No	Yes	IM	R Arm L Arm		
	LAIV4	Med-Immune	CH2063	12/8/14	0.2	Yes No	Yes	Intranasal	NA	8/19/14	
	PPV23	Merck			0.5	Yes No	N/A	IM SC	R Arm L Arm		

IIV3 = Inactivated influenza vaccine, trivalent
ccIIV3 = Cell culture-based inactivated influenza vaccine
IIV3 intradermal = Inactivated influenza vaccine, trivalent, intradermal
IIV3 High Dose = Inactivated influenza vaccine, trivalent, high dose
IIV4 = Inactivated influenza vaccine, quadrivalent
RIV3 = Recombinant influenza vaccine, trivalent
LAIV4 = Live, attenuated influenza vaccine, quadrivalent
PPV23 = Pneumococcal polysaccharide vaccine, 23-valent
PCV 13 =Pneumococcal conjugate vaccine

Provider Name: _____ MDPH Provider PIN#: _____

Provider Address:

_____